Testimony in Opposition to

LD 1496 An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions and Conditions Requiring Long-term Care by Changing Requirements for Prior Authorizations

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Senator Bailey and Representative Mathieson and distinguished members of the Health Coverage, Insurance and Financial Services Committee, my name is Kim Cook and I am an attorney with Government Strategies, testifying in opposition to LD 1496 on behalf of Community Health Options. Community Health Options is Maine's nonprofit CO-OP health insurance company and exists for the benefit of its Members and its mission which is to provide affordable, high-quality benefits that promote health and wellbeing.

We are supportive of our Members receiving the right care at the right time and we have minimized barriers to ensure they receive safe and effective health care. **We have removed prior authorization from at least 40 services over the last twelve months and in 2024 only 10% of the claims we processed were subject to prior authorization.**

Although often maligned, the **prior approval process is used by both public and private payors, including our state's Medicaid program, MaineCare**, because it ensures the care and prescriptions patients receive are clinically appropriate, medically necessary and aligned with current clinical guidelines as they evolve in response to peer-reviewed evidence. In addition, prior authorizations are used with respect to prescription drugs to ensure appropriate use and minimize harmful drug interactions and off-label use for diagnoses that lack evidence to support such use, among others.

Just one year ago, the Legislature enacted LD 796, An Act Concerning Prior Authorizations for Health Care Provider Services (PL 2024, c. 680) after holding six (6) work sessions over the course of the first and second sessions of the 131st Legislature. The Maine Medical Association and other stakeholders acknowledged throughout the debate over LD 796 that a clearer picture of the use of prior authorizations in the state-regulated market is essential in order for all parties to have the facts necessary for further policy development. The

Legislature, in addition to making several substantive changes to the Insurance Code related to prior authorization, agreed that actual data, not just anecdotes, is critical before making further changes to the law.

To address the lack of data, Part B-2 of LD 796 required carriers to report to the BOI annually a detailed set of ten (10) prior authorization metrics for their state-regulated health plans beginning this year and for the Bureau to post the data on its website. Importantly, the Committee provided itself the authority to report out a bill after receiving a report from the Bureau of Insurance, in recognition that once the Committee and stakeholders have a clear picture of the prior authorization usage and compliance by state-regulated plans, that it may seek to further amend the Insurance Code based on the new data. **In keeping with the Committee's prior direction, we urge the Committee to reject this bill or to carry it over so that you have the benefit of an accurate and complete picture of how prior authorization is being implemented in the state-regulated market.**

In addition, we oppose the provisions of LD 1496 because of the use of broad and undefined terms as well as the five-year length of time proposed for prior authorizations.

In Section 1 of the bill, prior authorizations would be required to continue for the duration of treatment (or one year if the duration is less than one year) for a "chronic condition" or a "condition requiring long term care." Neither of these terms are defined in LD 1496 nor in the Health Plan Improvement Act which this bill seeks to amend. Given the potential breadth of this language, this provision could essentially preclude the use of prior authorizations from many of the small set of services where we employ prior authorization today. This section further provides that if the duration of care is longer than one year, a carrier may not require prior authorization more frequently than every five years.

Section 2 of the bill would limit renewal of a prior authorization to once every 5 years for a prescription that continues for more than one year. Our formulary is regularly evaluated and updated. Over five years, a drug may be removed from the formulary, perhaps as a result of an excessive cost increase introduced by the manufacturer or, a generic version of the prescribed drug could be introduced. Under this bill's provisions, a prior authorization that specifies the brand name drug would be required to remain in effect despite these changes. In this way, LD 1496 would have both the patient and carrier continue paying a higher price than necessary. The prior approval process alerts providers to changes in the formulary and the availability of generic drugs, thus promoting savings for Members and the health plan.

We do not require prior authorization for many drugs that people take over the span of several years, like SSRI's or cholesterol drugs. In contrast, drugs that do require prior approval usually have high costs and significant side effects. These prescriptions often are treating conditions

for which new drugs are being developed. Some drugs, like opiates, require prior approval and are not intended for long term consumption. The prior approval process ensures that our Members receive appropriate care that reflects established medical guidelines.

Regarding the provisions of the bill aimed at ensuring patients can refill an existing prescription when they change health plans, we agree in concept, but note that the bill provisions are duplicative of provisions in current law addressing this potential concern. LD 1496 contains a proposal that would prevent carriers from restricting, "coverage for a prescription that received prior authorization approval under a previous health plan within 90 days of enrollment in the new health plan by an enrollee who is stable on that health care service…".

24-A MRSA §4303. Plan requirements

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.

Consistent with state statute, when an individual who received prior approval for a prescription drug leaves a carrier and enrolls in coverage offered by Community Health Options, we honor that authorization for up to 6 months after enrollment.

Thank you for the opportunity to provide our comments on this bill. We believe this bill will not have a positive impact on the health of our enrollees or the cost of healthcare. We encourage the committee to vote ought not to pass on LD 1496.